Child Abuse and Neglect Annual Report of Child Fatalities and Near Fatalities

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Division of Protection and Permanency
Department for Community Based Services
Cabinet for Health and Family Services

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Contents

Introduction

In accordance with KRS 620.050(12)(c), the Cabinet for Health and Family Services (cabinet), Department for Community Based Services (DCBS or department) submits this annual report of child abuse and neglect fatalities and near fatalities. A near fatality is defined by KRS 600.020 (39): "an injury that, as certified by a physician, places a child in serious or critical condition." This report provides insights into the demographics of the children who were the victims of abusive or neglectful deaths and near deaths as well as the circumstances around these events. This report focuses on child victims whose family had a protection service history with DCBS. The report is organized into four sections: Characteristics of Child Fatality and Near Fatality Cases; Trends in Child Fatality and Near Fatality Cases; Child Fatalities and Near Fatalities in State Fiscal Year (SFY) 2017; and State Program Improvement Efforts. Historical data in this report span five state fiscal years and include only child abuse and neglect fatalities and near fatalities in which the department had a previous assessment or investigation with the family.

Historical trend data presented in Table 1 have been updated from the annual report submitted in SFY 2016. An asterisk indicates that the number has been updated from previous reports. The numbers of child fatality and near fatality victims are subject to change as cases pending at the time of previous report writing are resolved. Alternately, cases that were initially reported as near fatalities, but ultimately ended in the child's death, have been updated to reflect the death. Additionally, numbers may fluctuate as a result of administrative hearings or court determinations requiring a change in finding. Fatality and near fatality cases for SFY 2017 are reported as they are reflected in the database at the time of the writing of the report.

Section I: Characteristics of Child Fatality and Near Fatality Cases

Case Demographics

From the completed cases of SFY 17, 29 child fatality and near fatality cases were identified as being the result of maltreatment. Of those 29 cases, 76% (22 cases) had prior involvement with DCBS. Of the 22 cases with prior involvement, 91% (20 cases) had a prior investigation or assessment within a 24-month period prior to the fatal or near fatal event. There were 15 victims of fatal or near fatal neglect maltreatment and seven findings of physical abuse.

Regional Differences

Table 1 shows the distribution of child fatality and near fatality cases in each of the nine DCBS service regions during SFY 2017.

Table 1:

Service Region (N=22)	# of abuse/neglect fatalities with prior involvement*	# of abuse/neglect near fatalities with prior involvement*	Total fatality/near fatality with prior involvement*
Cumberland	1	1	2
Eastern Mountain	0	0	0
Jefferson	2	1	3
Northeastern	0	2	2
Northern Bluegrass	0	3	3
Salt River Trail	0	3	3
Southern Bluegrass	1	0	1
The Lakes	1	1	2
Two Rivers	1	5	6
Statewide totals	**6**	**16**	**22**

*These numbers are as of the writing of the report and do not include unresolved cases or cases awaiting administrative hearings.

Section II: Trends and Demographics of Child Fatality and Near Fatality Cases Over Time.

In order to establish a context under which child death and serious injury occurs, general child maltreatment data are included in this report. Table 2 provides data from SFY 2017 on the overall number of calls with allegations received by DCBS, the total number of child abuse and neglect calls that met acceptance criteria, the number of substantiated abuse and neglect findings made by DCBS, and the number of fatality and near fatality victims. Though the number of fatality cases appears to be lower than previous years, there is no indication that the change is statistically significant.

Table 2:

	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
# of calls with allegations received		73,692^	106,197	105,527	110,585
# of abuse/neglect reports that met acceptance criteria	58,125	53,225	59,077	52,424	55,752
# of substantiated abuse/neglect findings	11,288	11,120	12,914	15,378	16,548
# of *fatalities* in which abuse/neglect was substantiated	20	16	21	19*	6
# of substantiated *fatalities* with agency prior involvement	15	12	16	13*	6
# of *near fatalities* in which abuse/neglect was substantiated	46	51	53	62*	23
# of substantiated abuse/neglect near fatalities with agency prior involvement	33	32	28*	34*	16

Note: An asterisk(*) indicates adjustment from prior years' reports.
^In 2014, DCBS made a system change that allowed for separation of allegation calls from all other agency calls; these data are unable retroactively for SFY 2013.

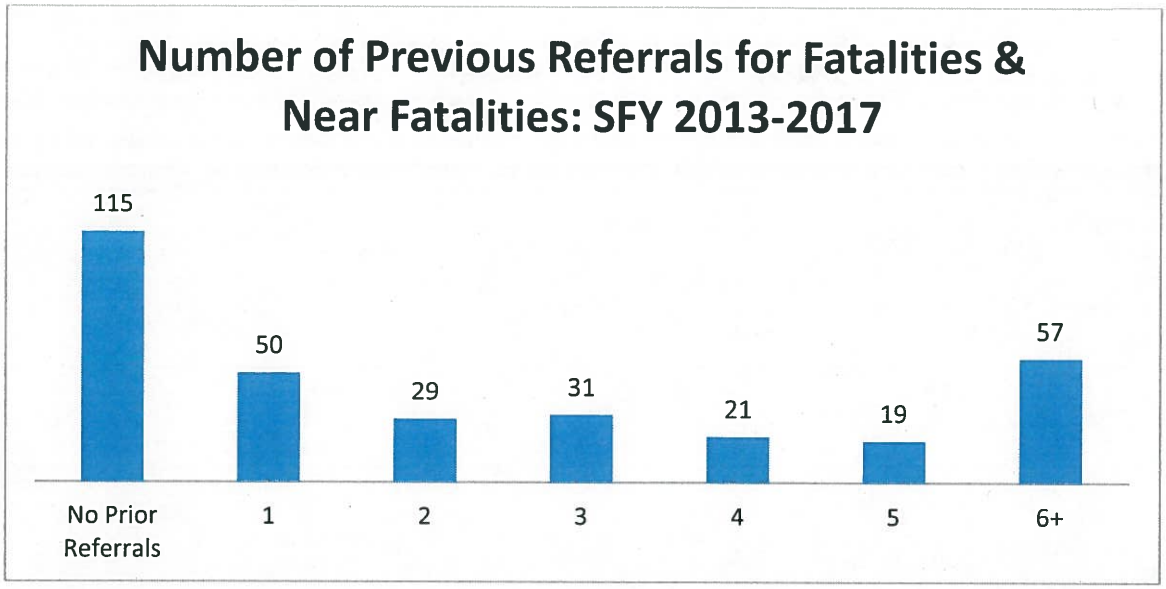
Source TWT Y084, Run Date 7/25/2017

Since the small number of child maltreatment cases that resulted in serious injury or death each year creates pronounced trend fluctuations and does not provide a representative picture of these cases, for this report, DCBS includes data over a five state fiscal year period (SFY 2013–SFY 2017) on all substantiated fatality and near fatality victims in which there had been prior protection and permanency involvement in order to strengthen the capacity to evaluate trends and describe characteristics for this report.

Prior Involvement

Prior involvement is defined as any assessment or investigation with a child or family in the area of protection and permanency. Figure 1 displays all 321 substantiated fatality and near fatality victims from SFYs 2013–2017. The data in Figure 1 are consistent with prior years' reports.

Figure 1:



In the past five state fiscal years, there have been 322 children who died or nearly died due to abuse or neglect (Figure 1.)

Of those children, 207 either had prior family or perpetrator involvement with DCBS. Section II of this report focuses on those 207 children. Of the 207 victims, 64 were fatalities, and 143 were near fatalities.

Child Victim Demographics

Nationally, children under the age of three die at a significantly higher rate compared to older children. According to the 2015 Administration for Children and Families (ACF) child maltreatment report, [1]nearly 74.8% of children who died from maltreatment were under the age of three. The ACF report does not include near fatal maltreatment, but one can see the number replicated in Kentucky with both fatal and near fatal maltreatment. In Kentucky, children age four and younger comprise over three-fourths (76%) of the maltreatment deaths and near deaths. Table 3 reflects the age of victims related to maltreatment fatalities and near fatalities.

[1] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2015.

Table 3:

Age of the Victim		
KY (n=207)		
Age	# of Children	Percentage
<1	81	39%
1	23	11%
2	27	13%
3	18	9%
4	11	5%
5-7	16	8%
8-10	9	4%
11-13	11	5%
14 +	11	5%

In Kentucky, male children are victims of a fatality or near fatality more than females. For SFY 2013–2017, 63% of the child fatality and near fatality victims are male, and 37% are female. Table 4 references the percentage of Kentucky's male and female victims compared to the national child fatality data.

Table 4:

Gender of the Victim		
	KY (n=207)	National Fatality Data (ACF 2015 NCANDS Report n=1,372)
Male	63%	54.6%
Female	37%	45.2%

In the United States, Caucasian children accounted for 42.3% of the child victims for fatal and near fatal maltreatment from SFY 2013-2017. Thirty percent of child victims were listed as African-American, 14.5% of child victims were listed as Hispanic, and 5.4% of child victims were identified as having two or more races. In Kentucky, African-American children are victims of fatal or nearly fatal maltreatment at a higher rate, 24.1 per 100,000 compared to Caucasian children at 18.9 per 100,000[2]. These data align with other data analysis conducted by DCBS, which indicates racial disproportionality between African-American children and Caucasian children. Table 5 displays the racial and ethnic backgrounds of child victims in Kentucky contrasted with national data.

[2] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2014.

Table 5:

Race/Ethnicity*	KY Child Population		KY (n=207) # of Children involved in a fatality/near fatality and also had prior involvement with DCBS		National Fatality Data (ACF 2015 NCANDS Report)**	
	#	%	#	%	#	%
African-American	91,960	9	32	15.5	368	30.6
American Indian or Native American	8,642	0.8	0	0.0	17	1.4
Asian	12,910	1.3	0	0.0	9	0.7
Hispanic*	49,949	4.9	4	1.9	175	14.5
Pacific Islander	643	0.1	0	0.0	2	.2
Unknown	***	***	***	***	58	4.8
Caucasian	828,136	80.9	161	77.8	509	42.3
Two or More Races	35,230	3.4	10	4.8	65	5.4

*Hispanic ethnicity is separate from race, not mutually exclusive
** States with more than 75% of race or ethnicity as unknown or missing were excluding from this analysis.

Perpetrator Demographics

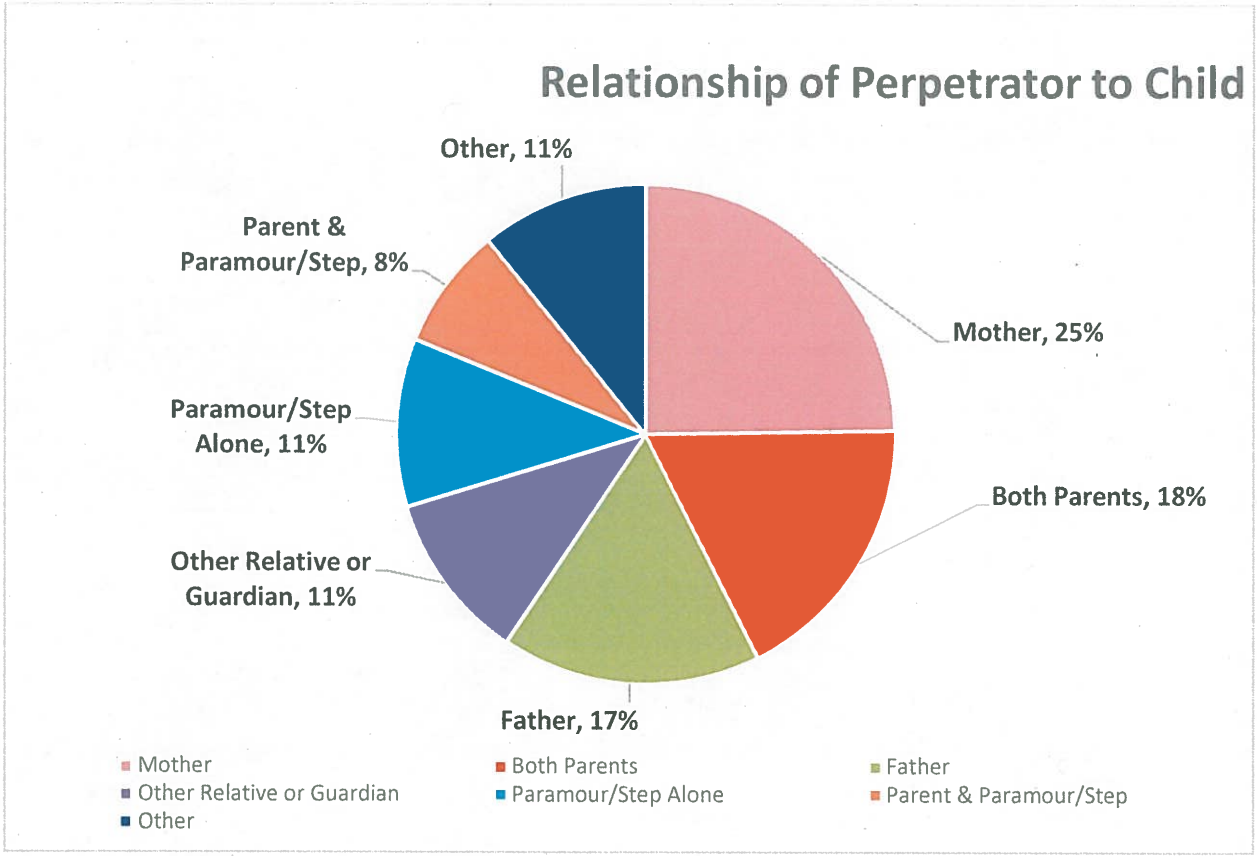
In the 207 cases that are the subject of this report, there are 273 identified perpetrators:

- There are 143 female perpetrators and 125 male perpetrators. There are five unknown perpetrators.
- Thirty-eight physical abuse cases had solely a male perpetrator, 15 physical abuse cases had solely a female perpetrator, and 24 physical abuse cases had a male and female listed as the perpetrators. There was one case with two female perpetrators, and one case had three males and two females as perpetrators (total of five perps.) This makes a total of 79 physical abuse cases.
- Sixty-three neglect cases had a female perpetrator, 23 neglect cases had a male perpetrator, and 36 neglect cases had a male and female listed as the perpetrator. This makes a total of 122 neglect cases.
- One case was a physical abuse and neglect case that had a male and female as the perpetrator.

For this and prior reports, female perpetrators were more frequently found in neglect fatalities and near fatalities while males tend to be the more frequent perpetrators of physical abuse cases.

Figure 2 displays the perpetrator relationship to the victim for the 207 children who are the subject of this section of report. In 29% (56) of the cases, there is more than one identifiable perpetrator responsible for the fatal or near fatal maltreatment, and in four of the cases, the perpetrator was unable to be determined. Data consistently show that parents, acting alone or in collusion with each other, are more often the perpetrators of fatal or near fatal child maltreatment. Nationally, only 13.3% of child fatalities had perpetrators *without* a parental relationship[3]. In Kentucky, 16% of child fatalities had perpetrators without a parental relationship.

Figure 2;



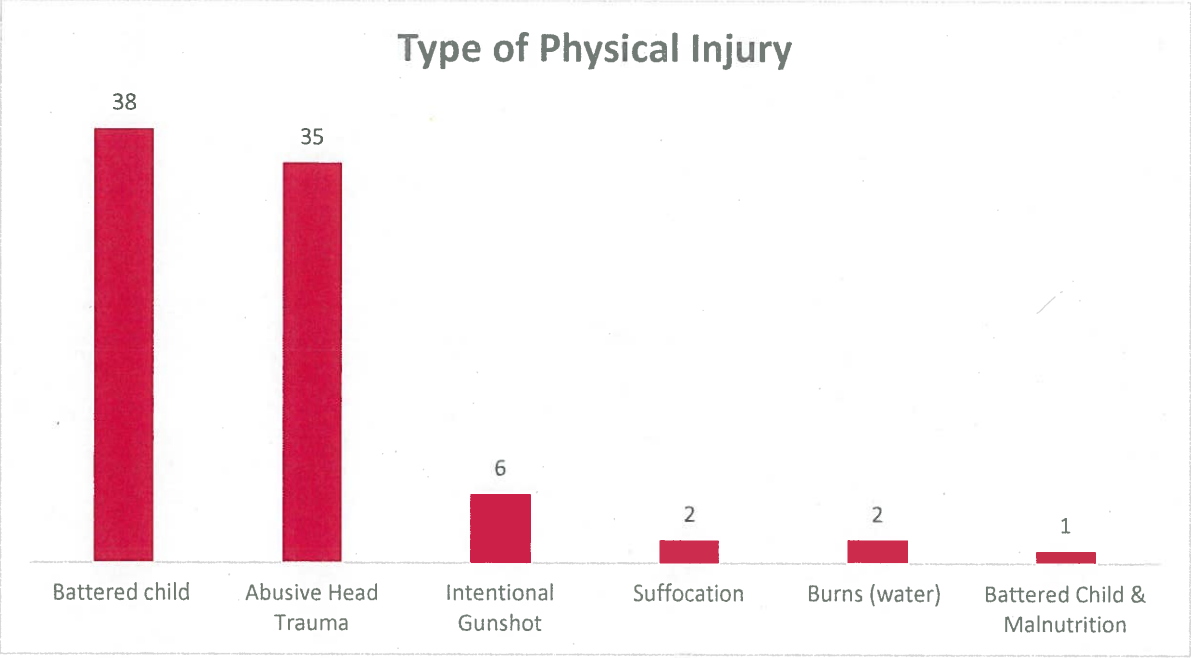
The average age for female perpetrators in Kentucky is 25 years old, and the average age for male perpetrators is 27 years old. Nationally, 83.2% of the perpetrators are between the ages of 18 and 44 years old.

[3] U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2014.

Maltreatment Type

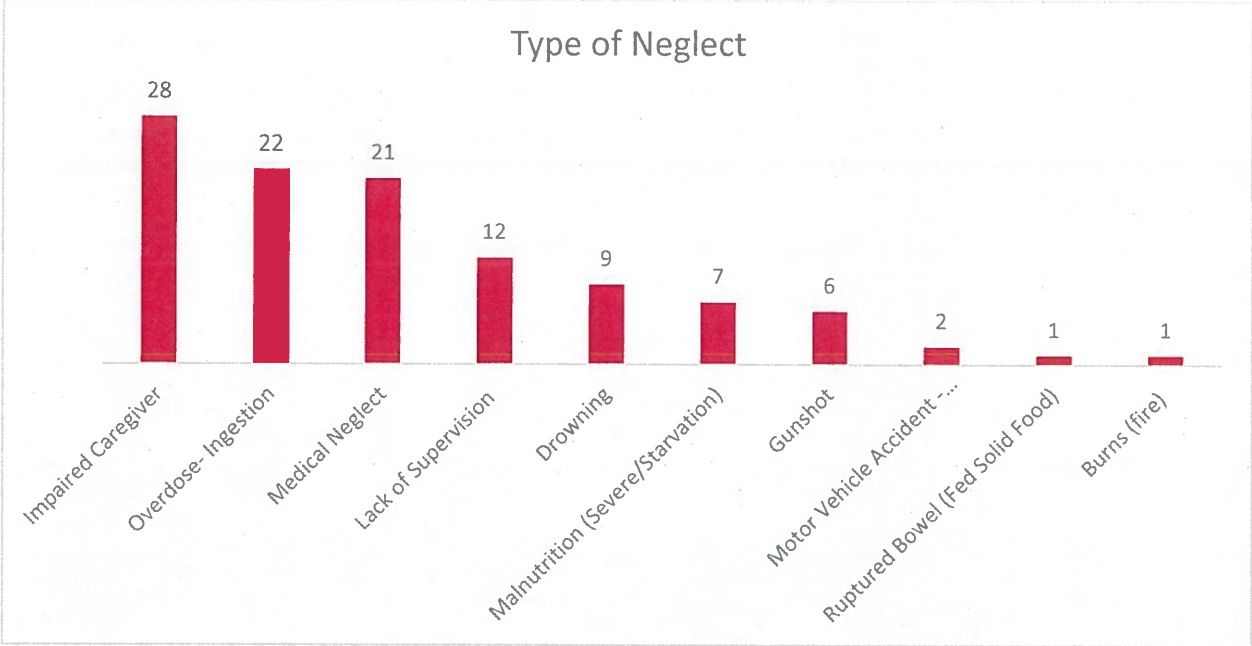
In this analysis, child maltreatment is broken into two categories: physical abuse and neglect. Of the 207 cases, physical abuse was substantiated as the cause 84 times, and neglect was substantiated 122 times with a total of 206 findings. In one case, the cause of the serious or critical condition was unable to be determined resulting in a finding of both neglect and physical abuse. Figure 3 displays the cause of death or serious injury in the 84 physical abuse findings for SFY 2013–2017. The leading cause of child physical abuse fatal or near fatal maltreatment is battered child (i.e., the child suffers multiple injuries) followed closely by abusive head trauma.

Figure 3



For SFY 2013-2017, the remaining 122 findings were considered a result of neglectful behavior. For purposes of this report, neglect types have been delineated into several different categories: impaired caregiver, overdose by ingestion, medical neglect, lack of supervision, drowning, malnutrition, impaired caregiver-motor vehicle accident, gunshot, positional asphyxia, domestic violence-motor vehicle accident, suffocation, burns, and a ruptured bowel. Impaired caregivers include any incident of death or near death for which the caregiver's substance use contributed to the maltreatment. Figure 4 delineates the causes of fatal and near fatal child maltreatment as a result of neglect. The most common category of neglect maltreatment that resulted in a fatality or a near fatality is from the impairment of the caregiver. This is followed by situations where a lack of supervision resulted in the victim overdosing on medication or other toxic substance and medical neglect.

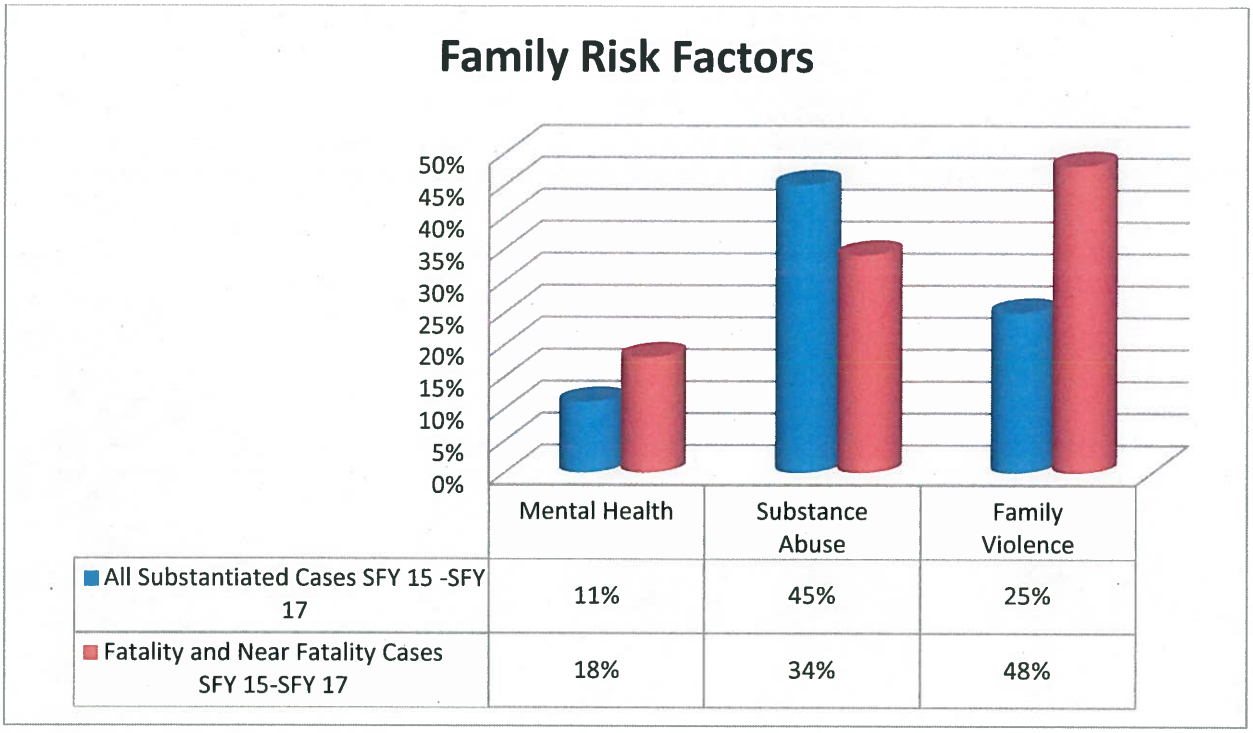
Figure 4:



Family Risk Factors

Abuse of or dependency on substances, family violence, and mental illness or cognitive impairment are commonly known antecedents in child abuse and neglect cases. DCBS collects data on how these three risk factors play a role in maltreatment. Data for the fatality and near fatality cases were collected for all substantiated cases completed in SFY 15 through SFY 17. In those years, there were 83 fatality and near fatality to consider as compared to all cases. In these 83 fatality and near fatality cases, substance abuse directly contributed to the maltreatment in 34% (28 cases). In SFY 17, substance abuse directly or indirectly contributed to the child maltreatment in 45% of all child protective services cases. Family violence was present in 48% of the fatal and near fatal maltreatment cases in SFY 15 through SFY 17, whereas it is noted as contributing to only 25% of all substantiations from SFY 17. Lastly, mental health or cognitive impairment directly or indirectly contributed to 18% of the fatality and near fatalities and 11% of the substantiated cases in SFY 17. Figure 5 displays the percentages substance abuse, family violence, and mental health as contributors in all substantiated or family-in-need of services cases contrasted with fatal and near fatal maltreatment.

Figure 5



A comparison of Figures 4 and 5 suggest some conclusions. Identification of risk factors can be useful for state administrators to establish prevention priorities; however, it is not necessarily a predictive feature that allows child welfare workers to triage risk and adjust cases for prioritization of services or other interventions.

Child Risk Factors

The age of the victim has been the one point of risk assessment that has consistently been useful as a predictive feature for caseworkers in cases. As aforementioned, 76% of children who were the victims of fatal or near fatal maltreatment were under the age of four. The age of children in neglect-related deaths or near deaths is more equally distributed among age groups, although the majority of victims tend to be aged four or younger. Figures 6 and 7 show the distribution of victim age in fatal and near fatal cases (N=207.) Infants are consistently more represented in fatal and near fatal cases. Figure 7 contrasts the age of the victim to the referral type.

Figure 6:

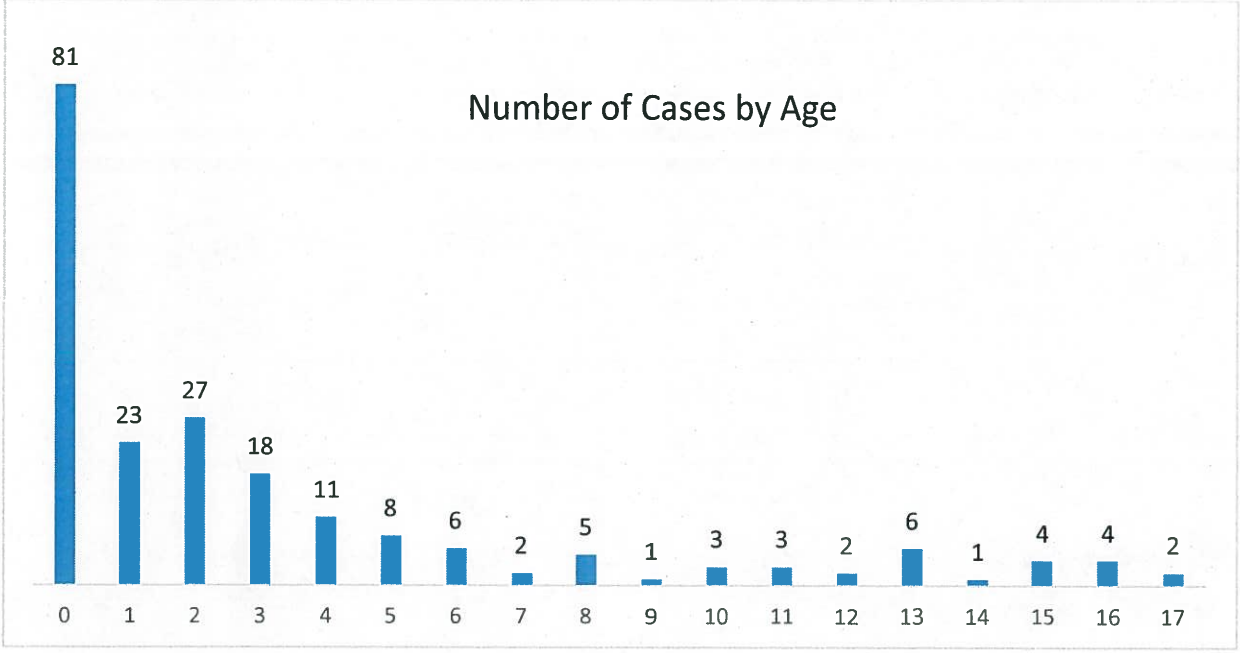
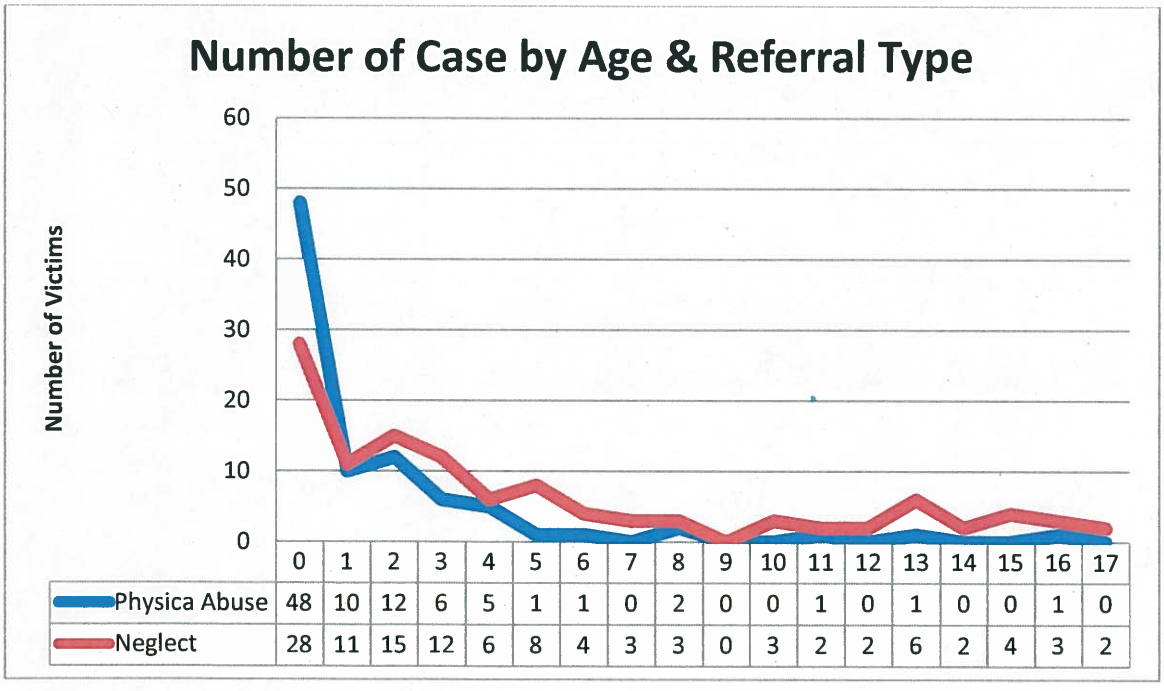
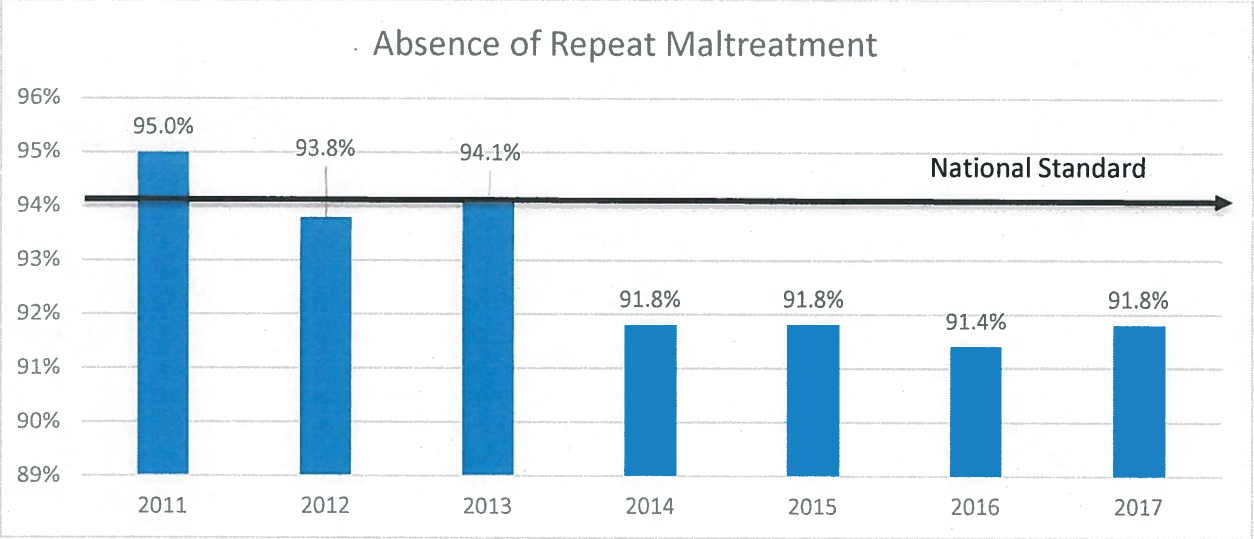


Figure 7:



The federally established national standard for absence of repeat maltreatment is 94.6%. States should strive to be above the 94.6% standard to demonstrate that agency interventions to prevent repeat maltreatment are successful. The Children's Bureau defines maltreatment recurrence as: "of all children who were victims of substantiated or indicated abuse or neglect during the first six months of a reporting year, what percentage did not experience another incident of substantiated or indicated abuse or neglect within a twelve-month period." Figure 8 displays Kentucky's overall absence of repeat maltreatment performance. Data labels in each year provide Kentucky's year-to-year comparison to the national standard. For the past six years, Kentucky's absence of recurrence rate has been below the national standard, as indicated by the black arrow line in Figure 8, per federal reporting available to date.

Figure 8:



Related to child fatalities and near fatalities, 12% (24) of the victims who are the subject of this report had repeat maltreatment. A review of these cases indicated potential missed opportunities in the areas of assessment of parenting skills, the ability of the caregivers to manage the tasks of daily living, and the caregiver's ability to prioritize the child's safety. Targeted case reviews performed by DCBS Division of Protection and Permanency staff also show a need for improvement in these areas. This is reflected in the state's performance related to absence of recurrence.

Section III: Kentucky's Program Improvement Efforts

Internal Reviews

Internal reviews are conducted on child fatality and near fatality cases as mandated by KRS 620.050(12)(b). Prior involvement is defined by 922 KAR 1:420 as "any assessment or investigation, of

which the cabinet has record, with a child or family in the area of protection and permanency prior to the child's fatality or near fatality investigation."

The internal review process was reviewed and enhancements were made at the end of SFY 15. To more closely align with the updated case review process, case review worksheets were developed that are applied to any assessment that was conducted in the 24 months preceding the fatal or near fatal incident. Action items are identified from the areas for improvement noted in the worksheets, and the regional staff strategizes ways to improve in those areas. Finally, regional staff monitors the identified areas through the continuous quality improvement case review scores. In SFY 17, the regions noted the areas needing most improvement include comprehensive assessments and initiation timeframes. There were few instances where the regions noted concerns regarding ongoing case tasks, including an absent parent or non-offending parent in the case plan process, but the majority of the tasks related to investigative assessments.

Program Improvement Efforts

(1) The lack of a comprehensive risk assessment[4] has been an area of concern in all previous annual reports. Adding corrective action items post-fatality to bolster worker risk assessment has not worked in isolation. In SFY 18, the fatality program is working with regional leadership to ensure that frontline supervisors' approvals of assessments are adequately addressing the risk and safety factors within each family. As a part of regular fatality reviews, fatality program staff have previously taken corrective action plans to focus on skill building; however, program staff have started to include items around regional efforts to review supervisor approvals and to ensure supervisors are only approving thorough assessments.

Data collected show the areas in the assessment needing improvement are that workers are not capturing the caregiver's tendency to become overwhelmed with daily tasks, ability to prioritize the child's safety, and the effectiveness of parenting skills. The results of the data analysis indicate that the department needs to continue its work to enhance their documentation to provide a more thorough risk assessments. In addition, the workers need to consistently capture the risks associated with the most vulnerable child within the home. Each region has developed its own method to implement improvements, including one-on-one meetings with the workers, holding regular staff meetings, and conducting region-wide trainings.

(2) The fatality program has added a third liaison in order to provide additional support to the regions. Having a lower volume of fatality and near fatality cases will allow each liaison to provide more timely support, training, consultation, education, and evaluation of regional systems.

(3) Kentucky has been invited to participate in a national program around fatality prevention, offered through a partnership between the National Conference of State Legislatures and the National Governors Association. The Three Branch Institute on Improving Child Safety and Preventing Child Fatalities has brought together a delegation from the three branches of government from eight states

[4] *"Risk assessment"* means the inability to identify protective factors, risk factors, and/or safety factors.

to help spread innovative practices designed to strengthen state practices around fatality and near fatality prevention. This technical assistance opportunity runs from June 2016 to December 2017.

(4) Kentucky completed its third federal onsite child welfare services review. The department is working with the federal oversight agency, ACF-Children' Bureau, and is currently in negotiations to develop a performance improvement plan. DCBS is also consulting with Capacity Building Center for States (through ACF's advisement) to build targeted interventions to support improvements in the child welfare safety program.

(5) Kentucky Strengthening Ties and Empowering Parents (KSTEP) is an in-home program for substance affected families being piloted in the Northeast region of Kentucky as July 1, 2017. KSTEP provides services to families with children under the age of 10 who are at high risk of entering out-of-home care. KSTEP is for families experiencing substance abuse risk factors known to be precursors to child abuse and neglect. KSTEP partners with contracted service providers to deliver evidence-based in-home services to address substance abuse. KSTEP emphasizes quick access to substance use treatment and support services, along with resources and collaboration among DCBS and community partners, to assist families with the help they need so their children can remain safely in their own homes. This is a waiver program under Title IV-E of the Social Security Act.

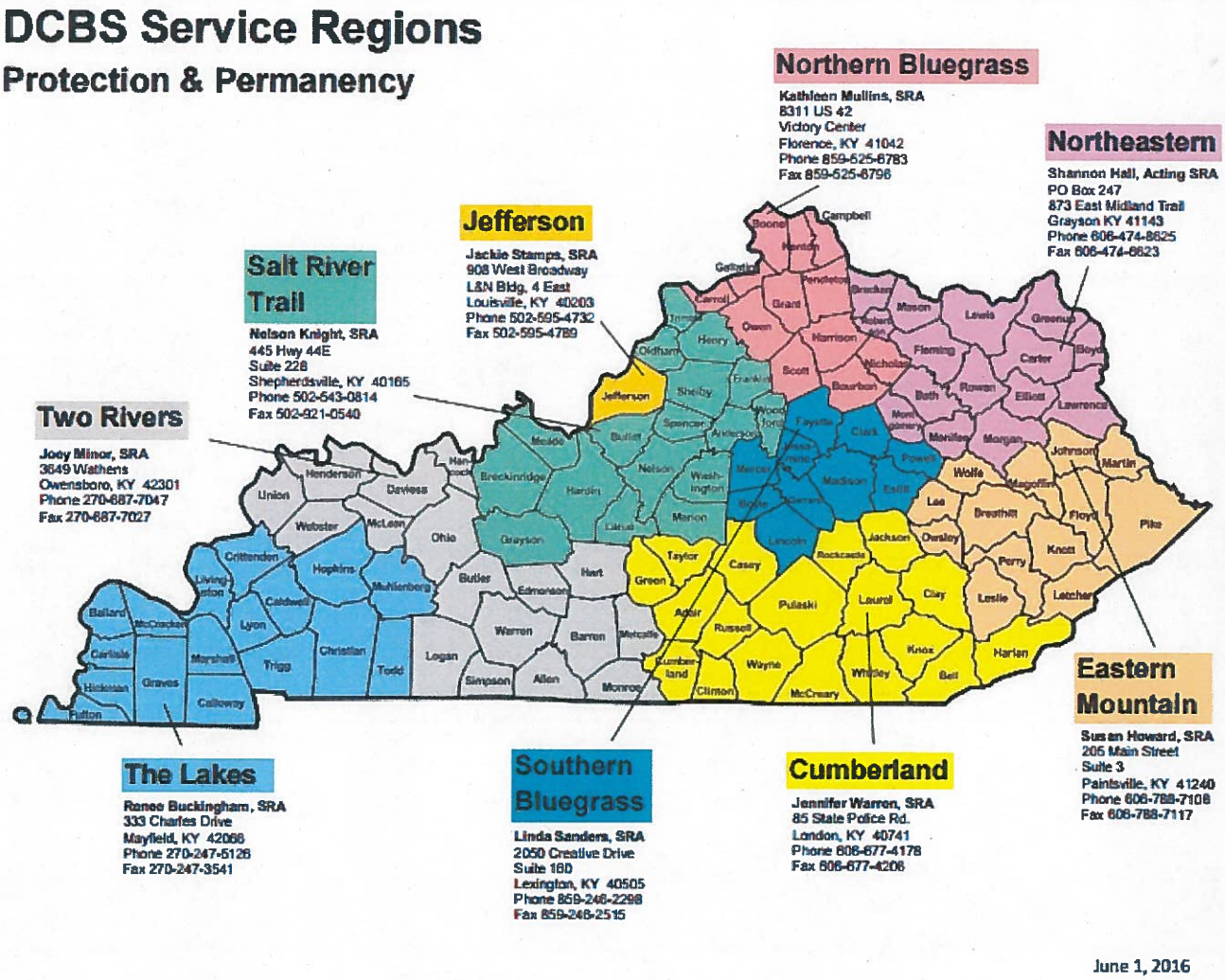
(6) The Kentucky Sobriety Treatment and Recovery Team (START) Program is an evidence-based DCBS program that works with families with co-occurring child maltreatment and parental substance abuse. START pairs specially trained DCBS social workers with family mentors (i.e., peer supports in long-term recovery from addiction) to engage families and quickly link families into services to keep children in the home when safe and possible. START partners with behavioral health providers to assure quick access to holistic assessment and treatment services. START is one of the interventions being used by DCBS under the federal Title IV-E Waiver demonstration project. By implementing START in a new site (Fayette County) and expanding capacity in three existing sites (Jefferson, Kenton, and Boyd Counties), DCBS intends to reduce the number of children whose parents have substance use disorders from entering foster care, thereby showing a cost-offset in foster care expense. A rigorous evaluation is in place to test the outcomes of START vs. typical child welfare services. START in Daviess County is currently completing the final year of a five-year Regional Partnership Grant (RPG) with ACF. A no-cost extension has been requested with the intention of continuing to serve families in Daviess START. The grant-funded evaluation of Daviess START outcomes will be completed in the next year.

Trainings

DCBS utilizes information gathered during internal reviews to shape training materials in order to enhance staff capacities. The Child Protection Branch participated in and/or provided several trainings to field staff this past state fiscal year:

- *"Risk Factors and the Assessment of Child Protective Services Investigations"* training emphasizes the assessment of domestic violence, mental health, and substance abuse in families. In addition, it strongly emphasizes the use of comprehensive interviews with service providers and family members to appropriately assess the strengths and needs of families. A team approach to training is used that includes both frontline staff and respective supervisors. This training is offered continuously on an as needed basis.
- *"Plan of Safe Care"* trainings were completed in all regions in conjunction with the 14 statewide community mental health centers. DCBS partnered with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to meet the requirements of the Comprehensive Addiction Recovery Act of 2016. Both agencies worked diligently with community partners. A grant was secured by DBHDID for Kentucky's community mental health centers to conduct trainings with appropriate community partners. The trainings were presented as a collaboration of efforts and highlighted the plan of safe care as being a community response. The trainings consisted of topics related to substance exposed infants and neonatal abstinence syndrome, adverse childhood experiences scores/trauma, substance abuse, medication assisted treatment, systems of care, motivational interviewing, and DCBS mandatory reporting.
- *"Centralized Intake Technical Assistance"* is a specialized training created by the department's Child Protection Branch and was provided to centralized intake staff in all nine service regions. This training provides information about child protective services and adult protective services acceptance criteria. It incorporates new information about screening intakes related to children who are four years of age and younger presenting with a physical injury of unknown origin. This training was specifically created to ensure that high-risk cases are identified and screened appropriately by centralized intake staff.

Appendix A: Regional Map



Appendix B: Data Tables

AGE OF CHILD	SFY 2013-2017 (n=207)		
	Fatality	Near Fatality	
Under 1 year	23	58	81
1 year	4	19	23
2 years	9	18	27
3 years	9	9	18
4-6 years	8	17	25
7-12 years	5	11	16
13-17 years	6	11	17
Total	**64**	**143**	**207**

GENDER OF CHILD	SFY 2017 (n=22)		SFY 2013-2017 (n=207)
	Fatality	Near Fatality	
Male	3	10	131
Female	3	6	76
Total	**6**	**16**	**207**

RACE/ETHNICITY OF CHILD	SFY 2017 (n=22)		SFY 2013-2017 (n=207)
	Fatality	Near Fatality	
African American	3	1	32
Two or More Races	0	0	10
White	3	15	161
Hispanic	0	0	4
Total	**6**	**16**	**207**

TYPE OF MALTREATMENT	SFY 2017 (n=22)		SFY 2013-2017 (n=207)
	Fatality	Near Fatality	
Physical Abuse	2	5	122
Neglect	4	11	84
Physical Abuse & Neglect	0	0	1
Total	**6**	**16**	**207**

PERPETRATOR RELATIONSHIP TO VICITM	SFY 2017 (n=22)		SFY 2013-2017 (n=207)
	Fatality	Near Fatality	
Mother	3	6	52
Father	3	0	36
Both Parents	0	4	37
Both Foster Parents	0	0	3
Parent Paramour/Step	0	3	38
Parent & Another	0	0	2
Alternate Care Provider	0	0	9
Other Relative	0	3	25
Unknown	0	0	5
Total	**6**	**16**	**207**